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In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

KENNETH KIZER, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Whether language in an internal agency manual prepared for use by field employees is a "legislative regulation" that binds the Secretary of Health and Human Services, even though it was never subjected to notice-and-comment rulemaking or published in the Federal Register, and even though it is contradicted by a regulation duly promulgated by the Secretary pursuant to the Administrative Procedure Act.

2. Whether Section 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112, prohibits the Secretary from disapproving proposed amendments to state Medicaid plans that conflict with statutory limitations on federal financial participation in the Medicaid program.

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BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 781 F.2d 1421. The opinion dissenting from the denial of rehearing en banc (Pet. App. 23a-35a) is reported at 794 F.2d 540. The opinion of the Administrator of the Health Care Financing Administration (Pet. App. 38a-45a) is unreported. The recommended decision of the hearing officer (J.A. 7-15) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 21a) was entered on February 7, 1986. An order

amending the panel opinion was entered on March 6, 1986 (Pet. App. 20a). A petition for rehearing was denied on July 14, 1986 (Pet. App. 22a). An opinion dissenting from the denial of rehearing en banc was filed on July 18, 1986 (Pet. App. 23a-35a). On October 3, 1986, Justice O'Connor extended the time within which to file a petition for a writ of certiorari to and including November 26, 1986. The petition was filed on that date, and was granted on February 23, 1987 (J.A. 69). The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of Sections 1902(a) and 1903(f) of the Social Security Act, 42 U.S.C. (& Supp. III) 1396a(a) and 1396b(f), of Section 2373 (c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112, of 42 C.F.R. 435.811 and 435.1007, and of Section 14005.12 of the California Welfare and Institutions Code (West Supp. 1987), are set out at Pet. App. 46a-49a.

STATEMENT

This case involves an effort by the State of California to afford a particular category of Medicaid recipients—medically needy adult couples—a level of Medicaid benefits that exceeds the statutory cap on federal financial participation. As a rule, of course, a state may be as generous or as parsimonious as it wishes with its own funds. In Section 1903(f) of the Social Security Act, however, Congress has established a ceiling on the income levels of individuals toward whose Medicaid benefits the federal government will contribute. Because it was clear that Cali-

fornia's proposed amendment to its state plan would increase Medicaid benefit levels to an amount in excess of this statutory cap, and because the state sought federal participation in financing that increase, the Secretary rejected California's proposal.

The court of appeals reversed. In holding that the Secretary was bound to approve California's proposed amendment, the court ignored a regulation duly promulgated by the Secretary that tracks the language of the statutory cap on federal financial participation. The court relied instead on a statement that had appeared some years earlier in an unpublished internal agency manual. It did not matter to the court that the Secretary had never endorsed the interpretation set forth in the manual, that the manual contradicted the Secretary's previously published regulation, that the manual satisfied none of the notice and publication requirements that regulations ordinarily must meet, that the statement in the manual was deleted from subsequent versions of the manual, or that the Secretary had declared the manual provision to be void ab initio. The court held that the manual was nevertheless a "proper legislative rule" that binds the Secretary (Pet. App. 13a). The court also held that the Secretary had no authority to enforce the income eligibility ceiling set forth as a condition of federal financial participation in Section 1903(f). For that conclusion the court relied on a provision in the Deficit Reduction Act of 1984 that by its terms has no bearing whatever on Section 1903(f).

A. The Medicaid Program

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Har-*

ris v. *McRae*, 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera*, No. 85-632 (June 23, 1986), slip op. 2. Medicaid is a cooperative federal-state program employing both state and federal funds. See 42 U.S.C. (& Supp. III) 1396b. The decision whether to participate in Medicaid is left to the discretion of each state. Once a state elects to participate, it must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services. See 42 U.S.C. (& Supp. III) 1396a; *Atkins* v. *Rivera*, slip op. 2; *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981). Upon obtaining the Secretary's approval of its Medicaid plan, a state is entitled to federal financial assistance for providing medical care to individuals who qualify under that plan. See 42 U.S.C. (& Supp. III) 1316(a), 1396, 1396a(b), 1396b(a).

Individuals covered by certain cash assistance programs—the Supplemental Security Income (SSI) Program, 42 U.S.C. (& Supp. III) 1381 *et seq.*, and the Aid to Families with Dependent Children (AFDC) Program, 42 U.S.C. (& Supp. III) 602 *et seq.*—automatically qualify for Medicaid. Thus, states that choose to participate in Medicaid must provide Medicaid benefits to these persons, termed the "categorically needy." See 42 U.S.C. (Supp. III) 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 433.110(a), 435.120(a); *Atkins* v. *Rivera*, slip op. 2; *Gray Panthers*, 453 U.S. at 37-39. In addition, and at its option, a participating state may provide Medicaid benefits to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965). In general, these are individuals whose income or resources somewhat exceed the eligibility levels for the SSI and AFDC programs, but who incur substantial medical expenses. These individuals are generally termed the

"medically needy." See *Atkins* v. *Rivera*, slip op. 3; *Schweiker* v. *Hogan*, 457 U.S. 569, 572-573 (1982). The "medically needy" qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard or if their income is below that standard. See 42 U.S.C. 1396a (a)(10)(C) and 1396a(a)(17); 42 C.F.R. 435.831 (c).

2. At the beginning of the Medicaid program, federal reimbursement was available to a state that elected to provide optional coverage to the "medically needy" regardless of how high the state chose to set its Medicaid eligibility income standard. In 1967, however, Congress determined that a limit on federal financial participation was desirable to guard against improvident Medicaid spending by the states. See *Schweiker* v. *Hogan*, 457 U.S. at 573, 576. Accordingly, Congress passed legislation to ensure that "[f]ederal sharing * * * not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." H.R. Rep. 544, 90th Cong., 1st Sess. 117, 119 (1967).[1] To effect that purpose, Congress enacted Section 1903(f)(1)(B)(i) of the Social Security Act, 42 U.S.C. 1396b(f)(1)(B)(i). That Section provides that federal financial participation is available only to the extent that the state limits its Medicaid eligibility income standard as follows:

> * * * the applicable income limitation with respect to any family is the amount determined, in

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[1] Typically, income levels for AFDC eligibility are the lowest among the categorical assistance programs. H.R. Rep. 544, *supra*, at 117, 119; see *Schweiker* v. *Hogan*, 457 U.S. at 577.

> accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the [AFDC] plan of [that] State * * *.

The Secretary issued regulations in 1971 pursuant to this directive. 36 Fed. Reg. 3871-3872. Those regulations, now codified at 42 C.F.R. 435.1007, reiterate the statutory requirement that a state's Medicaid eligibility income level must bear a fixed mathematical relationship to its AFDC eligibility income level for "a family of the same size." The regulations provide that, for couples and families of two or more, federal financial participation is available only when the state's Medicaid eligibility income level does not exceed "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources." 42 C.F.R. 435.1007(a)(1). See also 42 C.F.R. 435.811(c).[2]

B. Proceedings in this Case

1. Respondent Kizer is the Director of the California Department of Health Services; the other respondents are Medicaid recipients who intervened

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[2] The regulations promulgated in 1971 were initially codified at 45 C.F.R. 248.21(b)(2) and (3) (1972). They were recodified in 1974 at 45 C.F.R. 248.4(b)(4) (1974), and again in 1978 at 42 C.F.R. 448.4(b)(4) (1977). In September 1978, the regulations were amended to their present form and recodified at 42 C.F.R. 435.1007. The language at issue in this case ("family of the same size") has not undergone substantive change since the initial regulations were issued in 1971.

below. From 1976 to 1982, California had allowed a so-called "special income deduction" to medically needy adult couples (J.A. 58; see C.A. App. 80, 111, 275). The effect of this deduction was to set California's "medically needy income level," or "MNIL," for adult couples at a point above the ceiling established in Section 1903(f) as a condition of federal reimbursement. For that reason, the Secretary had disapproved California's pre-1982 eligibility levels (see C.A. App. 127, 275).

In June 1982, the California legislature amended the statute underlying the State's Medicaid plan by repealing the "special income deduction" (J.A. 58). The effect of this repeal was to revise downward the state's MNIL for medically needy adult couples and bring it into conformity with the ceiling set forth in Section 1903(f).[3] Consistently with Section 1903(f) and 42 C.F.R. 435.1007(a)(1), therefore, the State's 1982 amendment computed MNILs for all medically needy families, including medically needy adult

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[3] The effects of a reduction in the MNIL may be illustrated by a simplified example. Assume a "medically needy" family with monthly countable income of $300 and monthly medical expenses of $150. If the state's MNIL is $250, that family must pay the first $50 of its medical expenses, bringing its monthly income down to the Medicaid eligibility standard; at that point, the family may retain the remaining $250 of its monthly income for nonmedical needs and Medicaid will pay the other $100 of its medical costs. Now assume that the state lowers its MNIL to $200. That same family would then keep only $200 for nonmedical needs; Medicaid would cover only $50 of its medical bills, and the family would be responsible for the remaining $100 of its monthly medical expenses. As this illustration shows, the lower the MNIL, the smaller the proportion of medical expenses covered by Medicaid. Program costs further decrease with a lower MNIL because fewer people qualify for benefits.

couples, as 133⅓% of the maximum AFDC grant for a family of the same size. That formula produced an MNIL of $544 for a family of two (J.A. 58).

One year later, the California legislature perceived (see J.A. 60) what this Court had recognized in 1982, and what Congress had recognized in 1967 when it enacted the cap on federal financial participation: that because Medicaid eligibility income levels are linked to those for AFDC, which are typically "the lowest that are used in the categorical assistance programs" (H.R. Rep. 544, *supra*, at 119), the medically needy may end up with less income after paying their share of medical expenses than will some of the categorically needy. See *Schweiker* v. *Hogan*, 457 U.S. at 583, 584-588, 589-593 (rejecting statutory and constitutional challenges based on that fact). Thus, as a consequence of California's lowering of its Medicaid MNIL in 1982, the State's "[m]edically needy aged and disabled people experienced a very sharp increase in the share of [medical expenses] which they were required to meet each month in order to qualify" for Medicaid (J.A. 58-59).

In 1983, "under considerable pressure from recipient groups" (C.A. App. 127; see generally *id.* at 611-822; J.A. 60), the California legislature set about undoing the effects of the 1982 amendment. What California sought to do, in essence, was to increase Medicaid benefits for elderly couples, without making a correlative increase in AFDC benefits for families consisting of a parent and a child. Thus, while adjusting AFDC grant levels only slightly, California proposed a far more generous increase in benefits for two-person Medicaid families comprised exclusively of adults by raising the Medicaid MNIL for that class of recipients. The State sought to ac-

complish this revision by providing that the monthly MNIL for a family consisting of two adults would now be 133⅓% of "the highest amount that would ordinarily be paid to a family of *three* persons without income or resources under [the State's AFDC program]." Cal. Welf. & Inst. Code § 14005.12(c) (West Supp. 1987) (emphasis added). Since AFDC benefit levels were of course higher for a family of three than for a family of two, California's proposal would have had the effect of raising Medicaid benefits for elderly couples without necessitating a correlative increase in AFDC spending.

California's proposed 1983 amendment would thus have produced two significant changes in the State's Medicaid plan. First, it would have provided a different MNIL for a family of two adults than for a family of two comprising one adult and one child. Second, for a two-adult family, the statute would have established an MNIL with reference to an AFDC family of three rather than an AFDC family of two. In financial terms, the result would have been to leave the MNIL for a two-person family comprised of one adult and one child at $567 (133⅓% of the slightly higher 1983 AFDC grant for a family of two), while raising the MNIL for a two-person family comprised of two adults to $709, or $142 in excess of the maximum level permitted by Section 1903(f). See J.A. 24. The California legislature also provided specific instructions that the state agency was to follow in the event that the 1983 amendment was found to violate federal law.[4]

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[4] Section 124.7 of 1983 Cal. Stat. provided in part (C.A. App. 144-145):

> (a) * * * No provision of Section * * * 14005.12 of the Welfare and Institutions Code shall be considered to be in conflict with any federal statute or regulation until

2. Following enactment of California's 1983 legislation,[5] respondent Kizer's predecessor wrote to the Administrator of the Health Care Financing Admin-

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after a final determination of the Secretary of the United States Department of Health and Human Services * * *.

(b) In the event of an initial determination by the Secretary of the United States Department of Health and Human Services that any provision of this act is in conflict with any federal statute or regulation, the State Department of Health Services shall take all available and necessary steps to obtain a final determination reversing that decision. In the event of a final determination finding a conflict with federal law, the State Department of Health Services shall immediately request the State Attorney General to seek judicial review of the determination, and shall immediately notify the appropriate policy and fiscal committees of both houses of the Legislature.

(c) In the event of a final determination finding that any provision of this act conflicts with federal law, the State Department of Health Services shall adopt emergency regulations * * * if necessary to avoid withholding of federal reimbursement. The department shall further seek a federal waiver to permit implementation of the provision [found] to be in conflict with federal law, and shall continue to implement all [other] provisions of this act * * *.

[5] Even before the 1983 legislation was passed, it was recognized within the California Department of Health Services that the pending bill conflicted with federal requirements (C.A. App. 135, 327). The state agency had therefore considered several options as against the probability that the proposed amendment would be found to violate federal law. Among the options considered were a delay in implementing the portion of the amendment establishing a higher MNIL for two-adult families, implementing that provision and risking federal sanctions, and implementing the provision without seeking federal financial participation for benefits paid to persons whose income levels exceeded the federal limits (C.A. App. 136-137).

BEST AV

istration (HCFA), a subdivision of HHS, to request a "formal ruling" about the validity of California's provision setting new, higher Medicaid levels. Respondent stated that "[o]ur staff analysis has concluded that this provision not only exceeds the maximum limitation on Federal Financial Participation specified [in Section 1903(f)], but also that this provision is not in conformity with Section 1902(a)(10)(C)(i)(III) of the Social Security Act which specifies that the State must apply a single income standard to medically needy families of the same size regardless of family composition" (C.A. App. 140-141).[6] The HCFA Administrator's response, dated

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[6] Section 1902(a)(10)(C)(i)(III) of the Social Security Act, added by the Tax Equity and Financial Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378, 42 U.S.C. 1396a(a)(10)(C)(i)(III), requires that a state's Medicaid plan must establish a "single standard" for determining income and resource eligibility of a family of a particular size. This is the provision that later became a subject of the "DEFRA moratorium," the proper interpretation of which is involved in the second question presented by our petition in this case. See pages 41-49, *infra*. As respondent noted in his 1983 letter to the HCFA Administrator, Section 1903(f) and Section 1902(a)(10)(C)(i)(III) represented entirely distinct grounds for invalidating California's 1983 amendment to its Medicaid plan.

A simplified example will show how the 133⅓% cap of Section 1903(f) operates independently of the "single standard" rule of Section 1902(a)(10)(C)(i)(III). Assume a state where the highest monthly AFDC benefit ordinarily paid to a family of two is $300. If that state were to establish a Medicaid eligibility level of $350 for a family consisting of one adult and one child, and a separate level of $400 for a family consisting of two adults, a question could thereby be raised under the TEFRA "single standard" provision. But the 133⅓% cap of Section 1903(f)—viz., 133⅓% of $300, or $400—would not be exceeded in either event. Conversely, if

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September 6, 1983, concurred in respondent's conclusion that the 1983 California amendment, which fixed the two-adult MNIL by reference to the AFDC level for a family of three, violated federal statutory and regulatory requirements. The Administrator accordingly informed respondent that federal financial participation would to that extent not be available (C.A. App. 142-143).

California nonetheless attempted to implement its 1983 amendment, formally transmitting its proposal to amend its Medicaid plan to HCFA on September 20, 1983 (J.A. 22-24). The State's submission indicated that its proposed MNILs complied with Section 1903(f) "except for [the MNIL] for 2 adults," for whom the MNIL was "equal to 133⅓% of [the] AFDC payment level for 3 persons" (J.A. 23). Although the State expressly acknowledged that its proposed MNIL for two-adult families would exceed the federal participation cap by $142 per month (J.A. 24), it sought federal financial participation for the full amount of the proposed benefits to be provided to recipients whose incomes exceeded the federal limits. This was indicated by the State's having crossed out the following language that appears at the bottom of the preprinted transmittal form: "The agency has methods for excluding from its claim for [federal financial participation those] payments [which are] made on behalf of individuals whose income exceeds these limits" (*ibid.*).

3. In December 1983, the HCFA Administrator disapproved California's proposed plan amendment

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that same state were to set its Medicaid eligibility level for all families of two (whether consisting of two adults or of one adult and one child) at $450, there would be no question raised under the "single standard" provision. But the state would be in violation of the 133⅓% cap of Section 1903(f).

because it did not comply with the statutory and regulatory requirement that federal financial participation not be available where a state's Medicaid MNILs exceed 133⅓% of the maximum AFDC payment "to a family of the same size." See Section 1903(f); 42 C.F.R. 435.1007(a); J.A. 25-26. On February 16, 1984, the State requested reconsideration of the Administrator's decision (J.A. 31-33). A hearing was held on July 2, 1984 (J.A. 8).

The hearing officer recommended (J.A. 7-15) that the disapproval of California's proposed plan amendment should be affirmed. The State's main contention was that its proposed amendment was supported by language that appeared in a HCFA regional office manual issued in June 1979. In contrast to the statute and to the regulation promulgated by the Secretary in 1971, which require that a state's Medicaid MNIL be no more than 133⅓% of the state's maximum AFDC payment for a family "of the same size," the field manual said (§ 2572D) that "the States may set a separate * * * [MNIL] for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons" (see J.A. 21). The field manual also said that states "should have the option of establishing separate * * * [MNILs] for a two-person family consisting of one adult and one child and for a two-person family composed of two adults" (*ibid.*).

The hearing officer rejected the State's contention, concluding that the manual provision "is not a regulation, has no legal force and does not bind HCFA" (J.A. 14). He explained that the manual was "intended for internal regional office use, i.e., for the use of regional office employees only," emphasizing

that the manual's foreward "instructs regional office employees not to cite [the manual] to others" (*id.* at 10). The hearing officer accordingly found (*id.* at 11) that HCFA's office manual "if anything, has less, but certainly no more importance than the SSA Claims Manual" that was held not to constitute a binding regulation in *Schweiker* v. *Hansen*, 450 U.S. 785 (1981). At all events, the hearing officer concluded that "Congress [had] specifically rejected [the manual's] interpretation of section 1903(f)." J.A. 14; see *id.* at 12.

The hearing officer also rejected the State's alternative contention that Section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 1112, prohibited the Secretary from disapproving California's proposed amendment. The hearing officer explained that Section 2373(c) of DEFRA, the so-called "DEFRA moratorium," was "limited to violations of section 1902(a)(10)(C)(i)(III) of the [Social Security] Act." [7] The hearing officer pointed out that California's proposed amendment had been disapproved under Section 1903(f), not under Section 1902(a)(10)(C)(i)(III), and that the DEFRA moratorium "does not touch upon violations of section 1903(f)." J.A. 13.

On further administrative appeal, the HCFA Administrator issued a final decision upholding the hearing officer's recommended determination (Pet. App. 38a-45a). The Administrator observed that Section 1903(f) "provides for a single MNIL for a family of two" and that this limit is 133⅓% of the maximum payment ordinarily made under the State's

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[7] The operation of Section 1902(a)(10)(C)(i)(III) of the Act is described in note 6, *supra*, and is more thoroughly discussed at pages 41-47, *infra*.

AFDC plan "to a family of the same size without income and resources" (Pet. App. 42a). The Administrator further noted that the Secretary's regulation, which likewise speaks of AFDC payments "to a family of the same size" (42 C.F.R. 435.1007), was "absolutely clear regarding a family of two" (Pet. App. 42a). The Administrator found the language in the HCFA field manual to be "patently contrary to the statute and * * * , therefore, invalid from its origination," since "the Secretary is bound to follow the direction of Congress" (*id.* at 44a).[8]

4. On petition for review, a panel of the Ninth Circuit reversed the agency's determination (Pet. App. 1a-19a). The court acknowledged that Section 1903(f) restricted federal financial participation to cases where the state's Medicaid MNIL was no higher than 133⅓% of the highest AFDC payment "to a family of the same size." But the court said that this directive was tempered by other language in Section 1903(f), which required that the federal cap be determined "in accordance with standards prescribed by the Secretary" (Pet. App. 7a, citing 42 U.S.C. 1396b(f)(1)(B)(i) (emphasis omitted)). In the court's view, HCFA's 1979 regional office manual had prescribed just such a "standard," so that California could therefore set its adult-couple MNIL as high as "133⅓ percent of the AFDC payment level for a family of three persons." The court concluded that the manual set forth "a proper legislative rule" because it is a "rule 'issued by an agency pursuant to statutory authority and * * * implements the stat-

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[8] As had the hearing officer, the Administrator also rejected the State's alternative argument based on the DEFRA moratorium (Pet. App. 40a, 41a).

ute' " (Pet. App. 13a, quoting *Batterton* v. *Francis*, 432 U.S. 416, 425 n.9 (1977)).

Citing this Court's decision in *Schweiker* v. *Hansen*, 450 U.S. 785 (1981), the court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect" (Pet. App. 11a). But the court held that this case represented "an exception" to that principle, asserting that the office manual involved here was "not a field-level instructional guide" because it was supposedly "directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans" (*ibid.*). The court said that the 1979 version of the HCFA regional manual "establishe[d] the right of states to increase their adult couple MNIL" and "establishe[d] a new MNIL maximum * * * and thereby 'effect[ed] a change in existing law or policy' " (*ibid.*, quoting *Powderly* v. *Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983)).

Although the language in the field manual had never been subject to notice-and-comment rulemaking, and although it had not been published in the Federal Register or the Code of Federal Regulations, the court of appeals held that the manual had been properly promulgated as a "legislative regulation." The court noted (Pet. App. 13a) that the notice-and-comment procedures of the Administrative Procedure Act (APA) are generally inapplicable to matters relating to public benefits (5 U.S.C. 553(a)(2)). Although the Secretary by formal notice (36 Fed. Reg. 2532 (1971)) has voluntarily imposed the full panoply of APA procedural requirements upon HHS in such matters, the court stated that, in promulgating the manual, the Secretary had simply "failed to abide

by her predecessor's promise to adopt APA rule-making procedures" (Pet. App. 14a). On that basis, the court concluded that the absence of notice-and-comment proceedings did not deny the manual the force of law (*ibid.*).

With respect to the requirement of the Freedom of Information Act (FOIA) that agency regulations be published in the Federal Register (5 U.S.C. 552(a)(1)(D)), the court concluded that the FOIA requirement attaches only where nonpublication "would adversely affect a member of the public," a situation that the court found was not present here (Pet. App. 15a). The court therefore held that the manual was a lawfully promulgated regulation, exempt from the procedural requirements of the APA and the FOIA. And the Court held as an alternative ground of decision that "the DEFRA moratorium" in any event barred the Secretary from disapproving the proposed amendment to California's Medicaid plan (*id.* at 16a-18a).

5. The Secretary's suggestion for rehearing en banc was denied, with Judges Kozinski, Sneed, Hall and Noonan dissenting (Pet. App. 22a-35a). In the dissenters' view, "[t]he panel err[ed] in almost every respect" (*id.* at 26a). The dissent pointed out that HCFA's regional manual was "not a body of regulations," but rather was "an *office manual*, an internal directive from the agency's headquarters to its field offices" (*ibid.* (emphasis in original)). The manual's "[f]oreward," the dissent observed, stated that it was " 'for the use of regional office employees only,' " that it was " 'not intended to stand alone,' " and that it " 'should not be cited when addressing contractors, State agencies, providers, etc.' " (*id.* at 26a-27a (citation omitted)). Thus, even if

the manual were the only statement on the subject emanating from the government, the dissent concluded that the manual would not, under *Schweiker* v. *Hansen*, *supra*, constitute a "legislative regulation" with the force and effect of law.

The dissent went on to argue that this conclusion followed *a fortiori* here, since the Secretary had in fact promulgated valid regulations that "plainly conflict" with the manual section (Pet. App. 29a). Instead of deferring to these regulations, which explicitly link a family's Medicaid entitlement to that of an AFDC family "of the same size," the panel "effectively read[] the regulations out of existence without any explanation or admission of the fact" (*id.* at 30a). By subordinating formally promulgated regulations to an internal agency publication, the panel opinion, in the dissent's view, "tears asunder [the] tenets of administrative law" (*id.* at 31a) and "create[s] uncertainty where stability is vital" (*id.* at 32a). Judge Kozinski expressed concern that the panel opinion "will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned, internal guidelines will be found 'exceptional' enough to outrank regulations" (*ibid.*). And he pointed out that, even if the manual could be thought to be a "regulation," it would be invalid "because it violates the plain language of the statute" (*id.* at 30a).

The dissent also took issue with the panel's alternative holding based on the DEFRA moratorium. Relying in part on this Court's decision in *Atkins* v. *Rivera*, *supra*, the dissent pointed out that the DEFRA moratorium "has nothing at all to do with this case" since it was intended to restrict the Secretary's authority under a portion of the statute not involved

here (Pet. App. 34a). In Judge Kozinski's words (*ibid.*), "[t]he two provisions have about as much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees."

SUMMARY OF ARGUMENT

The court of appeals has raised the curtain on a revolution in administrative law. The court's principal holding is that a statement in an unofficial, unpublished, obsolete, internal agency manual can rise to the status of a "legislative regulation" that binds the agency, even though the statement is contrary to the plain language of the relevant statute and to the agency's own, duly promulgated rules. That holding does violence to settled principles of administrative law, thwarts specific congressional intent, and substantially undermines federal fiscal control over the Medicaid program.

1. In setting the statutory cap on federal financial participation in the Medicaid program, Congress spoke clearly and directly. A state is entitled to federal participation in Medicaid if the state's Medicaid eligibility level for a family of a given size does not exceed 133⅓% of the highest amount ordinarily payable in monthly AFDC benefits "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i)). There is no mystery to this language; no enigma that can be deciphered only by Medicaid cognoscenti. California's proposed amendment failed to qualify under this statute because a family of three is not the "same size" as a family of two.

Although the clarity of the statutory language makes resort to its legislative history unnecessary,

we note that the legislative history fully supports our view. In adopting the House version of Section 1903 (f) in preference to the more expansive limit proposed by the Senate, Congress evidenced its intent to keep on a relatively short tether those states that chose to provide federally-supported assistance to the medically needy. Nothing in the legislative history supports the construction of the statute that the court of appeals has advanced.

Even if the statutory language or the legislative history left room for uncertainty, it would be eliminated by the consistent official interpretation of the agency charged with administering the statute. Duly promulgated regulations issued by the Secretary have, since 1971, incorporated verbatim the statutory "same size" requirement; these regulations fit comfortably within the category of regulations that are entitled to "legislative effect" (*Atkins* v. *Rivera*, slip op. 7). At all events, the Secretary has never interpreted the statute as conferring the authority discovered by the court of appeals: the authority to decree that a family of two is the "same size" as a family of three.

The court of appeals, brushing aside the agency's officially published rules, chose instead to treat as a "legislative regulation" a statement contained in a regional office manual in 1979. That statement, which was contrary to the plain language of the statute, which was never endorsed by the Secretary, which was never published in the Federal Register or the Code of Federal Regulations, which was deleted shortly after it first appeared in the manual, and which was rejected in the administrative proceedings in this case as a nullity, is not a "regulation" at all, much less a "legislative regulation." Indeed, even if

the manual provision had been the only relevant pronouncement emanating from the agency, it would still have to be rejected as contrary to Congress's stated intent.

Unless reversed, the decison below will undermine Congress's longstanding requirement that the cap on federal financial participation in Medicaid be set according to the "family of the same size" standard. More generally, the decision below would seriously disrupt the orderliness and regularity of the administrative process. If rules duly promulgated by the Secretary can be subordinated, as the court of appeals held, to informal, internal communications by lower-level employees, then all government officials—and those subject to regulation—will be left to guess which statutes and regulations will be similarly supplanted by ill-considered and anonymous memoranda.

2. The court of appeals also erred in concluding that the DEFRA moratorium precludes the Secretary from enforcing the statutory cap on federal financial participation contained in Section 1903(f). On its face, the DEFRA moratorium is expressly confined to the Secretary's authority under a different section of the statute, and the moratorium makes no mention of Section 1903(f), the section on which the Secretary based his action here. The legislative history of the DEFRA moratorium confirms that Congress had no intention to prevent the Secretary from enforcing the cap on federal financial participation; indeed, Congress specifically rejected a provision that would have accomplished the very result that respondents urge. There is, ultimately, no conceivable reason why DEFRA, a deficit reduction measure, should be interpreted in a way that divests the Sec-

retary of authority to enforce the statutory limit on the federal government's fiscal participation in Medicaid.

ARGUMENT

I. THE SECRETARY CORRECTLY DISAPPROVED CALIFORNIA'S PROPOSED AMENDMENT BECAUSE IT FAILED TO LINK A FAMILY'S MEDICAID ELIGIBILITY LEVEL TO THE AFDC ELIGIBILITY LEVEL OF A FAMILY OF THE SAME SIZE

A. Section 1903(f) And Its Implementing Regulation Expressly Condition Federal Financial Participation On A State's Establishment Of A Medicaid Eligibility Level That Is No Higher Than 133⅓% Of The State's Highest AFDC Payment For "A Family Of The Same Size"

1. This Court has often observed " 'that the legislative purpose is expressed by the ordinary meaning of the words used.' " *United States* v. *James*, No. 85-434 (July 2, 1986), slip op. 6. There can be no serious doubt that the ordinary meaning of the words used in the Social Security Act appears to settle the question presented here. Section 1903(f) of the Act provides that, for Medicaid purposes, "the applicable income limitation with respect to any family" is "133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, * * * under the [AFDC] plan of the State" (42 U.S.C. 1396b(f)(1)(B)(i)). California proposed, by contrast, to compute its Medicaid income limitation for certain families of two as 133⅓% of the highest AFDC benefits ordinarily payable to a family of three. Under normal English usage, a family of three and a family of two would not be regarded as being "the same size." The plain

language of the statute thus makes clear that California cannot claim federal reimbursement for the added Medicaid costs occasioned by its 1983 plan amendment.

Because the statutory language is unambiguous, there is no need in this case to "turn to the legislative history as an additional tool of analysis" (*Garcia* v. *United States*, 469 U.S. 70, 75 (1984); see *United States* v. *Rojas-Contreras*, No. 84-1023 (Dec. 16, 1985), slip op. 4). But examination of that legislative history lends no support whatever to respondents' contentions. Rather, it adds compelling support to our view that Congress never intended to authorize the Secretary to compute Medicaid eligibility in the manner California wishes. Cf. *INS* v. *Cardoza-Fonseca*, No. 85-782 (Mar. 9, 1987), slip op. 10-11 n.12.

At the inception of the Medicaid program, Congress left it to the states to establish Medicaid eligibility and benefit levels, and hence placed no limit on the amount of federal reimbursement that a state could claim for providing optional benefits to the "medically needy." "Within a year," however, "Congress recognized that it was fiscally improvident to rely exclusively on the States to set income limits" (*Schweiker* v. *Hogan*, 457 U.S. at 575). In 1967, therefore, Congress established a limit on federal financial participation. After extensive hearings, the House reported a bill that proposed to limit federal financial participation to "133⅓ percent of the highest amount ordinarily paid to a family of the same size (without any income and resources) in the form of money payments under the AFDC program." H.R. Rep. 544, *supra*, at 119. The House Report specifically noted that "AFDC income limits are, generally

speaking, the lowest that are used in the categorical assistance programs." *Ibid.*

The Senate acknowledged that the House bill had the objective of "substantially limiting Federal financial participation in the medicaid program." S. Rep. 744, 90th Cong., 1st Sess. 176 (1967). But while it agreed that some restriction on federal financial participation was needed, the Senate devised "an alternative way of accomplishing the basic purpose of the House bill" (*ibid.*). The Senate alternative was to cap federal financial participation by limiting Medicaid eligibility to 150% of the state's Old Age Assistance (OAA) level. Because the OAA program was typically the most generous of the federal cash assistance programs, the Senate alternative would have permitted states to obtain federal funding for much higher Medicaid benefits than under the House bill. S. Rep. 744, *supra*, at 177.

The Senate alternative was rejected in conference. See *Schweiker* v. *Hogan*, 457 U.S. at 579-580 n.15; H.R. Conf. Rep. 1030, 90th Cong., 1st Sess. 63 (1967). Senator Robert Kennedy observed that "[t]he Senate conceded, in conference, almost every provision where its approach was more liberal than that of the House * * *." 113 Cong. Rec. 36783 (1967). Senator Mondale explained the House provision, which he had opposed, as follows (*id.* at 37819):

> The House bill limits Federal participation in title 19 programs to those whose income is less than 133 percent of the highest amount ordinarily paid families of similar size under the State aid-to-dependent-children programs.

It was this provision of the House bill, firmly linking a family's Medicaid eligibility to the AFDC eligibility

of a family of the "same size," that was enacted into law. No mention was made of giving the Secretary authority to alter that legislative determination in any respect.[9]

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[9] In view of the legislative history of Section 1903(f), the concerns that prompted California to propose its 1983 plan amendment, no less than the literal terms of that amendment, are at odds with congressional intent. California's proposal was animated by the perception that some "medically needy" persons, after paying their share of medical expenses, could end up with less income than some "categorically needy" persons, such as SSI recipients. See J.A. 58. But Congress plainly recognized that this could happen and intended that result, since it deliberately chose to link Medicaid eligibility to income levels under the least generous (AFDC), rather than under the most generous (OAA), categorical assistance program.

The fact that Congress chose to limit federal financial participation in this way, of course, does not preclude a state from establishing more generous Medicaid benefits payable out of the state's own funds. Indeed, the printed form on which proposed state plan amendments are transmitted to HCFA (see J.A. 24) specifically contemplates that a state desiring to exceed federal limits will confirm that it has established methods for excluding from its claim for federal financial participation those payments made to individuals whose income exceeds federal limits. A state that so confirms will continue to receive the federal share of Medicaid payments made to individuals whose incomes do not exceed the federal limits. In other areas, California has decided to pay benefits exclusively from state funds, *e.g.*, Cal. Welf. & Inst. Code § 14005.4 (West Supp. 1987) (medically indigent program). But, as we have noted (see pages 11-12, *supra*; J.A. 24), California did not pursue that course here; it opted instead to exceed the federal limits *and* to seek federal participation. See C.A. App. 272-274, 570, 572, 573, 590-592, 598, 600, 835-837.

Another option available to a state seeking to provide more generous Medicaid benefits to adult couples without exceeding federal limits is simply to increase the amount of its AFDC payments to a family of two. Since the Medicaid 133⅓%

2. If the statutory language left any doubt about Congress's intent to peg the "medically needy" eligibility standard for Medicaid benefits to the state's AFDC level for a family of the "same size," that doubt would be resolved by the Secretary's lawfully promulgated regulation. Consistently with the language of the statute, the Secretary has prescribed by regulation that federal financial participation is available only when the state's MNIL does not exceed, for couples and families of two or more, "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources" (42 C.F.R. 435.1007(a)(1)). The Secretary has administered the Medicaid program in this fashion, pursuant to this regulation and its predecessors, for more than 16 years. See 43 Fed. Reg. 45217 (1978); 36 Fed. Reg. 3871-3872 (1971); see note 2, *supra*. Regulations of this type are entitled to "legislative effect," as this Court recently explained (*Atkins* v. *Rivera*, slip op. 7 (citations omitted)):

> Because the Secretary's regulation appears supported by the plain language of the statute and is adopted pursuant to the explicit grant of rulemaking authority * * *, it is " 'entitled to more than mere deference or weight.' " * * * Indeed,

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cap is keyed to the AFDC level, an increase in the latter necessarily increases the former. Once again, however, California did not pursue that course; it left the AFDC level substantially unchanged while attempting to raise the Medicaid level above the 133⅓% cap. Thus, the issue in this case is not whether California may provide additional assistance for the medical needs of adult couples, but rather whether California may enlist in that effort federal financial participation in excess of the limits set by Congress.

> it is entitled to "legislative effect," * * * and is controlling "unless [it] is arbitrary, capricious, or manifestly contrary to the statute[.]"

3. Although the court of appeals quoted the Secretary's regulation (Pet. App. 6a), it proceeded at once to ignore it. The panel did not find the regulation unclear or ambiguous, nor did it explain how the regulation could be read to permit the result California wanted. Rather, the court purported to find ambiguity in the statute itself. It theorized (Pet. App. 7a, 14a) that the express statutory cap in Section 1903(f) was qualified by other statutory language, language that delegated authority to the Secretary to prescribe standards for determining the amount that is "equivalent to 133⅓ percent of the highest amount which would ordinarily be paid" to an AFDC family of the same size. In essence, the court held that this latter language granted the Secretary discretion to determine that a family of three is the "same size" as a family of two, and that the Secretary had in fact prescribed such a standard.

This reasoning suffers from a variety of defects. To begin with, if the court wished to consult the Secretary's "standard" for performing the mathematical exercise set forth in the statute, the court was obligated to look to the regulation, described above, which the Secretary had promulgated. See 42 C.F.R. 435.1007. As we have explained, that regulation contains no suggestion that a family of three could be deemed to be the "same size" as a family of two. Thus, if the statute were thought ambiguous or incomplete in the absence of "standards prescribed by the Secretary," that ambiguity, as Judge Kozinski

said, "is neatly excised by these regulations" (Pet. App. 30a).

Moreover, even if the Secretary had never promulgated a regulation, it is obvious that Section 1903(f) would not authorize him to prescribe a standard under which a family of two and a family of three would be judged to be "the same size." Rather, the "standards" that the Secretary was authorized to prescribe are those for determining which of a state's AFDC payment levels for a family of a given size is the "highest" that would "ordinarily be paid" to a family of that size. For example, because a state's AFDC program may allow additional benefits to be paid for "special needs" (see 45 C.F.R. 233.20(a)(2)(v)),[10] a state may sometimes pay different amounts to families of a given size depending upon the recognized special needs of family members. There are also certain situations, specified by statute, in which a MNIL must be determined for a medically needy family for which the state's AFDC plan may have no counterpart—*e.g.*, a family of one or a very large family. See 42 U.S.C. 1396b(f)(3), 1396b(f)(1)(B)(ii). It is in these situations that the Secretary was meant to prescribe standards for determining the "highest amount which would ordinarily be paid" to an AFDC family of the same

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[10] "Special needs" payments may cover such circumstances as special nutritional needs or diets, utilities, transportation, education, day care, pregnancy-related needs, clothing, and catastrophic events. Thirty states, the District of Columbia, and Guam have chosen to make AFDC "special needs" payments. See generally Office of Family Assistance, Social Security Administration, U.S. Dep't of Health & Human Services, *Characteristics of State Plans for Aid To Families With Dependent Children Under the Social Security Act Title IV-A* (1986).

size. Once those standards have been employed, one can then multiply that "highest amount" by 133⅓% to derive the maximum MNIL the State may establish for a Medicaid family of that size.

Congress plainly did not delegate to the Secretary the authority to determine that a family of three is the same size as a family of two. To conclude, as did the court of appeals, that the Secretary may prescribe standards that treat two as equal to three is to nullify the statutory requirement of equivalence. "Read in this fashion," Judge Kozinski aptly stated in his dissent, "the statute provides no limits whatsoever on the Secretary's discretion and might as well say 'the Secretary may set the MNIL any way he pleases' " (Pet. App. 31a). In any event, the Secretary has never sought to utilize the discretion, attributed to him by the court of appeals, to pronounce that two equals three.

B. The Court Of Appeals Erred When It Elevated A Provision In An Agency Field Manual Over The Language Of The Statute And The Secretary's Regulation

Even if the Secretary were thought to have discretion to prescribe standards under which a family of two would be deemed to be "the same size" as a family of three, the court of appeals plainly erred in concluding that the Secretary had in fact prescribed such a "standard" in the guise of HCFA's regional office manual. The court ruled that language contained in the 1979 version of the manual—language that was never published in the Federal Register or subjected to normal rulemaking procedures, and which was in conflict with the statutory mandate—was a "legislative rule" that "establish[ed] the right

of states to increase their adult couple MNIL" (Pet. App. 11a). That ruling cannot be reconciled with established principles of administrative law.

1. It is well settled that "not all agency publications are of binding force" (*Lyng* v. *Payne*, No. 84-1948 (June 17, 1986), slip op. 11). Indeed, if agencies were bound by every pronouncement made on their behalf, there would be little reason for Congress to have codified notice-and-comment procedures in the Administrative Procedure Act. Agency manuals, in particular, are a species of agency pronouncement that lack the force and effect of law. *Schweiker* v. *Hansen*, 450 U.S. at 789; *United States* v. *Caceres*, 440 U.S. 741 (1979); *American Farm Lines* v. *Black Ball Freight Service*, 397 U.S. 532 (1970); *Sullivan* v. *United States*, 348 U.S. 170, 172-174 (1954).

In *Schweiker* v. *Hansen*, *supra*, a Social Security claims representative incorrectly told a claimant that she did not qualify for statutory insurance benefits. He also failed to advise her that she should file a written application for benefits, although the Social Security Claims Manual instructed claims representatives to give such advice. In refusing to estop the government from enforcing a lawful condition on the receipt of benefits, this Court acknowledged that the claims representative failed to follow the procedures specified by the Claims Manual. The Court held, however, that "the Claims Manual is not a regulation. It has no legal force, and it does not bind the SSA." 450 U.S. at 789. The Claims Manual, rather than being a compilation of binding regulations, was considered to be only a "handbook for internal use by thousands of SSA employees * * *." *Ibid.*[11]

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[11] In the administrative proceedings in this case, the hearing officer observed that the regional manual on which the court

The court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect," but said that the manual provision at issue here, for two reasons, constituted "an exception" (Pet. App. 11a). First, the court asserted that this provision "establishes a new MNIL maximum in [the adult-couple] category and thereby 'effect[s] a change in existing law or policy' " (*ibid.*, quoting *Powderly* v. *Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983)). As Judge Kozinski pointed out, however, the panel's reasoning in this respect "merely assumes the conclusion. A provision can effect a change in existing law or policy only if it has the force of law; if it does not, it cannot" (Pet. App. 28a). Under the panel's reasoning, moreover, an *incorrect* manual provision would almost always be deemed a "legislative rule with binding effect," since an incorrect manual provision would typically "effect a change in existing law or policy." Conversely, a manual provision that conformed to existing law would not have "binding effect" because it would correctly state the law rather than change it. This would be quite an odd result.

The second reason advanced by the panel to justify treating the manual provision as a "legislative rule" was that the manual was assertedly not directed to office-level agency employees, but instead to "states and a major category of recipients under state plans" (Pet. App. 11a). But, as Judge Kozinski explained, the panel's rationale "flies in the face of [the manual's] own description of itself," for the manual ex-

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of appeals relied "if anything, has less" authoritative force than the Claims Manual that this Court ruled in *Hansen* was not a binding regulation (J.A. 11).

plicitly says that it " 'is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc.' " (*id.* at 28a (emphasis and citation omitted)). Plainly, the manual was not intended for use by anyone other than HCFA employees. See *Schweiker* v. *Hansen*, *supra*.

The court of appeals failed to acknowledge both the expressly limited purposes of *this* manual, and the limited purposes of agency manuals in general. Moreover, the court failed to explain how the manual, despite its explicit disclaimer, could be regarded as "a legislative rule issued pursuant to statutory authority" (Pet. App. 16a). Even respondents did not contend below that the manual constituted a "legislative rule," and in this court they expressly disavow any reliance on the court of appeals' characterization (see Br. in Opp. 17 n.6).[12]

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[12] Respondents suggest that the court of appeals' characterization of the manual as a "legislative rule" was superfluous, and that the court "could well have rested its judgment upon the ordinary deference which this Court and the court of appeals have given similar regulatory material" (Br. in Opp. 19). This suggestion is without merit because characterization of the manual as a "legislative rule" was essential to the court of appeals' reasoning. The court distinguished *Schweiker* v. *Hansen* and similar cases on the ground that, "[u]nlike the statutes interpreted by the agency manuals in [those] cases * * *, Section 1903(f) expressly authorized the Secretary to prescribe 'standards' " (Pet. App. 13a). The court reasoned that the instant manual was such a "standard," and that, because it was supposedly issued pursuant to an explicit statutory directive, it was a "proper legislative rule" and hence to be distinguished from the agency manuals involved in previous cases. In any event, contrary to respondents' statement, a manual provision that contradicts the express language of the statute and of duly promulgated regu-

2. A principal factor showing that the manual provision does not have the force and effect of law is that it was not issued pursuant to statutory rulemaking authority of the Secretary. "[T]o have [lawful] 'force and effect,'" this Court has stated, a regulation must be " 'issued by an agency pursuant to statutory authority.' " *Chrysler Corp* v. *Brown*, 441 U.S. 281, 301-302 (1979) (citation omitted). As Judge Kozinski correctly observed (Pet. App. 29a), Congress has granted authority to promulgate rules and regulations implementing the Medicaid program to "the Secretary alone" (see 42 U.S.C. (Supp. III) 1302). The Secretary, moreover, has never delegated the authority to promulgate regulations to the Administrator of HCFA, much less to any subordinate HCFA employee. See 42 Fed. Reg. 57352 (1977); 44 Fed. Reg. 31045 (1979). "Like thousands of other internal guidelines issued every year by scores of federal agencies," Judge Kozinski explained, the manual provision at issue here was "issued anonymously; the Foreword alone is signed and that by the Director of the Bureau of Health Insurance, an official far subordinate to the Secretary" (Pet. App. 29a). "Guidelines issued by someone without authority to promulgate regulations are simply not regulations" (*ibid.*). See *General Electric Co.* v. *Gilbert*, 429 U.S. 125, 141 (1976).

Agency discretion to promulgate rules is also circumscribed by the "procedural requirements imposed by Congress." *Chrysler Corp.* v. *Brown*, 441 U.S. at 303. Both the Administrative Procedure Act and the Freedom of Information Act require that a rule be

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lations, and that suffers from the other deficiencies we have described, is not "regulatory material" to which any "deference" is due.

published before it can be deemed to have *any* force and effect. The manual provision was never published in either the Federal Register or the Code of Federal Regulations.[13] The United States Court of Appeals for the District of Columbia Circuit, speaking through Judge (now Justice) Scalia, recently observed: "The real dividing point between regulations [and other agency pronouncements] is publication in the Code of Federal Regulations, which the statute authorizes to contain only documents 'having general applicability and *legal effect.*'" *Brock* v. *Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 539 (1986) (quoting 44 U.S.C. 1510(a) (emphasis in original)). A statement in an agency field manual that does not spring from the Secretary's statutory rulemaking power, that was not the subject of notice-and-comment rulemaking, and that was never officially published cannot "bind" the Secretary.

3. Finally, even if the manual provision could be deemed a procedurally-sound substantive rule issued under a proper grant of statutory authority, the manual provision would still be invalid because it obviously conflicts with the language of the Social Security Act. The Act prescribes a strict formula for the calculation of the cap on federal financial participation: a state's Medicaid MNIL for a family of a given size can be no higher than 133⅓% of the

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[13] Respondents describe the regional office manual (Br. in Opp. 4) as a document "published by HHS' Health Care Financing Administration." Respondents also refer to the manual as a "published interpretation[]," by which they mean that "it was published in the CCH Medicare & Medicaid Guide" (Br. in Opp. 21). This sort of "publication," of course, is irrelevant in determining whether printed matter is an agency "regulation."

state's maximum AFDC payment to a family of the same size. In sharp contrast, the manual suggests (§ 2572D) that the states may set a standard for two adults "between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons" (J.A. 21). In light of the statutory language, the manual provision was, as the HCFA Adminstrator held, a nullity (Pet. App. 44a). The Secretary's long-standing regulation mandates the same conclusion. That regulation has been in effect since 1971 and has never been repealed, unless the court of appeals means to say that the manual provision "repealed" the regulation. Administrative regularity dictates that as between a duly promulgated, officially published regulation and an agency field manual, it is the former, not the latter, that is binding.[14]

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[14] Although one can only speculate about the genesis of the erroneous manual provision, the error may have stemmed from an incorrect extrapolation from Medicaid rules governing families of one person. The manual states (see J.A. 18) that the provision at issue here was drafted in response to an inquiry concerning the establishment of a separate MNIL for two adults; the manual surmised that this question was "similar" to the establishment of an MNIL for a family of one, a question that had been addressed in response to an inquiry made in 1976 (*ibid.*). There are, to be sure, similarities between setting MNILs for families of one and two. But there are also substantial differences, which the manual provision ignored. The most important distinction is that Congress dealt separately with each, in different sections of the Social Security Act. Section 1903(f)(1)(B)(i), which is at issue here, and which establishes the 133⅓% cap in relation to AFDC families of the "same size," addresses family sizes for which the state's AFDC program has specific income levels. The statutory prescription for establishing the MNIL for a family of one is contained in Section 1903(f)(3); it does not

4. There is nothing persuasive about the verbal and logical gymnastics in which the court of appeals engaged in an effort to fit the manual provision into the mold of a regulation. The court suggested, for example, that notice-and-comment procedures were not applicable here because the manual provision concerns matters relating to "public benefits" (see 5 U.S.C. 553(a)(2)). But in 1971 the Secretary had voluntarily waived the "public benefits" exception by formally stating that HHS regulations would comply with the APA procedural requirements. See 36 Fed. Reg. 2532 (1971). Quite apart from the question whether this voluntary waiver is binding on the Secretary to the same degree as procedural requirements imposed directly by Congress (see, *e.g.*, *National Welfare Rights Organization* v. *Mathews*, 533 F.2d 637 (D.C. Cir. 1976)), the Secretary's decision not to subject the HCFA manual to notice-and-comment procedures plainly shows that *the Secretary* did not regard that manual as a regulation. And it is certainly no answer to infer, as did the court of appeals (Pet. App. 14a), that the Secretary in issuing the

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employ the 133⅓% cap based on a family of the "same size," since an AFDC family of one is not the norm and, as Congress anticipated, some states may not have established AFDC income levels for a family of one. Rather, Section 1903(f)(3) says that the state shall calculate its Medicaid MNIL for a family of one "on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons" (42 U.S.C. 1396b(f)(3)). The manual thus appears to have erred in transposing to a family of two the statutory standard that applies to a family of one. This is also suggested by the manual's citation of 45 C.F.R. 248.4(b)(4)(ii)(A) (1976) as the source for the manual's description of " 'reasonably related' income levels." See J.A. 21. That regulation is expressly limited to single-member families.

manual simply "failed to abide by her predecessor's promise to adopt APA rulemaking procedures," for that is to posit a presumption of agency irregularity.

The court of appeals acknowledged, moreover, that the Freedom of Information Act does not exempt benefits-related regulations from the publication requirement. The court parried that thrust by asserting (Pet. App. 15a (citation omitted)) that the FOIA publication requirement attaches only where nonpublication " 'would adversely affect a member of the public,' " and that the HCFA manual, although unpublished, was nevertheless a valid "legislative rule." But putting to one side the question whether an agency's failure to publish a regulation in the Federal Register will invariably invalidate it, the Secretary's action in not publishing the instant manual provision plainly shows that the Secretary did not regard it as a "regulation" at all, least of all a regulation effectively revoking prior regulations duly promulgated under the APA.

5. The practical effect of the decision below will be to make every agency publication, however informal, a "potential regulation," and thereby wreak havoc on federal agencies and the public. Under the administrative regime contemplated by the court of appeals, the regulations set forth in the Federal Register and the Code of Federal Regulations will be subject to contradiction, revision or repeal by far less formal, and certainly less official, pronouncements made by lower-level employees. As Judge Kozinski put it, agency officials "will now have to guess which of their informal, unsigned, internal guidelines will be found 'exceptional' enough to outrank regulations" (Pet. App. 32a). That is surely not the law. *Schweiker* v. *Hansen*, *supra*; *Heckler* v.

Community Health Services, 467 U.S. 51, 63-64 (1984); *Federal Crop Insurance Corp.* v. *Merrill*, 332 U.S. 380, 384 (1947).

Even more damaging than this, perhaps, is the court of appeals' statement that anonymous, internal agency pronouncements retain "the force and effect of law" unless "repealed," or, possibly, until "removed from publication" (Pet. App. 13a, 16a). The manual provision at issue here was in fact deleted from the superseding HCFA regional manual issued in July 1980, three years before California proposed the instant plan amendment. Until the decision below, one would have thought that an agency's revision of its office manual would terminate whatever effect (binding or otherwise) a predecessor version might be deemed to have. Apparently not. Although the government in its petition for rehearing (at 9 n.3) informed the court of appeals that the HCFA manual had been revised and the relevant language deleted in 1980, the panel took no cognizance of that fact. The court seems to have held, in other words, that the Secretary must engage in formal notice-and-comment rulemaking to revise an office manual, even though the manual's supposed status as a valid "legislative rule" rested on the court's antecedent conclusion that notice-and-comment rulemaking was not required when the manual was issued in the first place.

C. The Secretary Cannot Be Estopped From Obeying The Law On The Theory That The State Relied On The Manual Provision At Issue

In their brief in opposition (at 4, 20, 21), respondents refer to California's supposed "reliance" on HCFA's regional office manual when it passed the 1983 amendment to California's Medicaid plan. These statements have the flavor of an "estoppel" argu-

ment. But the court of appeals found no estoppel, and respondents themselves seem to disavow any estoppel theory in another part of their brief. See Br. in Opp. 25. If that is so, assertions about California's "reliance" on the manual are completely beside the point.

In any event, it is clear that California did not in fact rely on the manual. The hearing officer found that California did not rely on it (J.A. 12, 14). The Administrator of HCFA agreed that "reliance was never established" (Pet. App. 44a), and the court of appeals did not disturb that finding. The manual provision upon which the legislature allegedly relied in 1983 had in fact been deleted from the manual in July 1980 (see page 38, *supra*); and the affidavit submitted by a "principal co-author of the bill in the [State] Assembly" makes no reference to the manual (J.A. 61). Moreover, California's legislative enactment itself evidences an awareness that the proposed amendment would be disapproved by federal authorities, for it contains explicit and rather unusual instructions to be followed by the state agency in the event the 1983 amendment was found to violate federal law (see note 4, *supra*).

The administrative record likewise demonstrates that California officials were well aware that the proposed 1983 amendment was contrary to federal law. The 133⅓% federal reimbursement cap was scarcely unknown to the State, since it was the basis for HCFA's disapproval of the "special income deduction" that California had employed prior to 1982 (see page 7, *supra*). While the 1983 amendment was pending before the California legislature, respondent Kizer's predecessor wrote to the Administrator of HCFA, advising that "[o]ur staff analysis

has concluded that this provision * * * exceeds the maximum limitation on Federal Financial Participation" specified in Section 1903(f) and 42 C.F.R. 435.1007 (C.A. App. 140-141; see *id.* at 135). An earlier "Decision Memo" prepared by the state agency acknowledged the perceived conflict with federal requirements and assessed several options that could be employed to secure the "intended results," including a proposal to "implement [the] State statute to the extent possible without incurring loss of federal monies" (*id.* at 135-138). Respondent Kizer's predecessor had advised the author of the pending California legislation that his agency opposed the amendment in question, stating that "we don't believe federal approval of [the Assembly bill] would be granted" (C.A. App. 327; see J.A. 54). The HCFA Administrator in September 1983 explicitly told California that its proposed adult-couple MNIL would exceed the 133⅓% cap of Section 1903(f), and respondents concede (Br. in Opp. 5) that the State was advised of the problems with the amendment well in advance of the legislative enactment.[15]

At bottom, respondents' reliance argument seems to be that, while state officials knew that California's proposed 1983 amendment would be disapproved by federal authorities, they were unsure what the exact basis of that disapproval would be. Respondent Kizer's predecessor had identified two potential prob-

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[15] The Chief of the Eligibility Policy Section of California's Department of Health Services (see C.A. App. 231) explained that her department had initially opposed implementing the 1983 amendments inasmuch as "every federal official and staff member that I talked to and all of our letters indicated there is no way they are going to approve it, it seemed like a futile exercise" (*id.* at 281).

lems with the state's proposal—that it would produce an adult-couple MNIL in excess of the 133⅓% cap of Section 1903(f), and that it arguably violated the "single standard" rule of Section 1902(a)(10)(C)(i)(III).[16] Respondents seem to argue that California "relied" on the expectation that its proposed plan amendment would be rejected as violative of the "single standard" provision, whereas the basis for the HCFA Administrator's rejection was in fact the 133⅓% federal cap. But that scarcely bolsters respondents' contention that the State Plan amendment should therefore have been approved.

II. THE SO-CALLED "DEFRA MORATORIUM" DOES NOT IMPAIR THE SECRETARY'S AUTHORITY TO DISAPPROVE CALIFORNIA'S PROPOSED MEDICAID PLAN AMENDMENT

The court of appeals overturned the Secretary's determination on the alternative ground (Pet. App. 16a-18a) that the Secretary was barred by the so-called "DEFRA moratorium" from disapproving California's proposed plan amendment. The court of appeals reasoned, in other words, that even if the HCFA field manual was not a "regulation," with the result that disapproval of California's proposal was mandated by Section 1903(f), the Secretary was nevertheless prevented from taking that course by Congress's action in 1984. This reasoning betrays a serious misunderstanding of both the Secretary's decision and the scope of the DEFRA provision.

1. As we have explained, the sole basis upon which the hearing officer and the HCFA Administrator relied in disapproving California's proposed plan

[16] We discuss the latter provision more fully in the context of the "DEFRA moratorium" below.

amendment was the 133⅓% cap established by Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f). An altogether different question—not implicated in the agency's decision to disapprove California's proposal—may arise under Section 1902(a)(10)(C)(i)(III) of the Act, 42 U.S.C. 1396a(a)(10)(C)(i)(III). That provision, added to the statute in 1982, required that a state's Medicaid plan establish a "single standard" for determining income and resource eligibility. That latter provision was initially read by some HHS employees (though not by the Secretary) to require that a family of two consisting of one adult and one child must have the same Medicaid eligibility level as a family of two consisting of two adults. It was this interpretation of the "single standard" provision—*i.e.*, requiring that all families of the same size be treated identically under Medicaid, regardless of how many adults are in the family—that some Congressmen criticized as an "overly literal" reading of the enactment. See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1367 (1984). And it was this interpretation of the "single standard" provision (and of another provision that had also been enacted in 1982)[17] that was the subject of the DEFRA moratorium enacted in 1984.

The DEFRA moratorium, Pub. L. No. 98-369, § 2373(c)(1), 98 Stat. 1112, reads as follows (emphasis added):

> The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State

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[17] The 133⅓% cap was of course enacted in 1967, some 15 years previously.

> during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined *to be in violation of section 1902(a)(10)(C)(i)(III) of such Act* on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

The "moratorium period" was defined as "the period beginning on the date of the enactment of this Act and ending 18 months" after the Secretary submitted a specified report to Congress. Pub. L. No. 98-369, § 2373(c)(2) and (3), 98 Stat. 1112.

By its terms, the DEFRA moratorium speaks only of regulatory action against a state under Section 1902(a)(10)(C)(i)(III) of the Social Security Act. The moratorium makes no mention of Section 1903(f), or of the 133⅓% cap set forth therein. As we have explained (note 6, *supra*), moreover, Section 1902(a)(10)(C)(i)(III) and Section 1903(f) impose wholly distinct limitations on a state's Medicaid plan. The former Section arguably requires that all Medicaid families of a given size must have the same income eligibility level; it thus focuses on relative entitlements within the Medicaid system. Section 1903(f), by contrast, specifies an absolute dollar cap on federal financial participation in Medicaid, linking the Medicaid eligibility of any family to the AFDC eligibility of a family of the same size. Thus, regardless of whether, under Section 1902(a)(10)(C)(i)(III), a two-person family consisting entirely of adults must be treated the same as a two-person family consisting of one adult and one child, Section 1903(f) says that federal financial participation will

not be available if the Medicaid MNIL for *either* family exceeds 133⅓% of the state's highest payment to a two-person family under its AFDC program.

2. The legislative history reinforces the statutory language. It shows that Congress not only limited the DEFRA moratorium to subjects other than those involved in this case, but also that Congress specifically rejected a proposal that would have accomplished the precise result that respondents obtained in the court of appeals.

Some members of the House of Representatives did disagree with the Secretary's implementation of Section 1903(f). The House Committee on Energy and Commerce therefore recommended amending Section 1903(f) to provide explicitly that a state could set its Medicaid income level for two adults by reference to the State's highest AFDC payment ordinarily made to a family of three. H.R. 4136, 98th Cong., 1st Sess. § 211 (1983). But that amendment was rejected in conference, and DEFRA contains no such provision. The Conference Report explained (H.R. Conf. Rep. 98-861, *supra*, at 1361):

> Present law
>
> Medically needy income levels for an SSI-related family of two adults with no income or resources, many [*sic*] be set at a level no higher than 133⅓ percent of the AFDC standard for a two-person family with no income or resources.
>
> House bill
>
> The House bill permits States to establish medically needy levels for a family of two adults up to 133⅓ percent of the three-person AFDC standard.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

Respondents have attempted to disengage themselves from the consequences of that legislative determination by attributing to Congress motives that appear nowhere in the legislative history. Thus, respondents suggest that Congress rejected the proposed House amendment to Section 1903(f) because it was "too limited" and would be redundant in light of the "broader" moratorium (Br. in Opp. 6). But, as the plain language and the legislative history show, the moratorium provision is not as broad as respondents propose. To the contrary, it is expressly limited to Section 1902(a)(10)(C)(i)(III), and it cannot rationally be thought to apply by implication to Section 1903(f), since Congress expressly *declined* to amend Section 1903(f) in that way.[18]

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[18] This Court recognized in *Atkins* v. *Rivera*, slip op. 12 n.10, that Congress's sole purpose in enacting the DEFRA moratorium was to override regulations the Secretary had issued following the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357. See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1366-1368 (1984); *Camacho* v. *Perales*, 786 F.2d 32, 42 (2d Cir. 1986). The regulations at issue in this case were initially promulgated in 1971, and have been unchanged since 1978; these regulations were accordingly not affected by TEFRA or by the related DEFRA moratorium.

The context of the DEFRA moratorium further bolsters the conclusion that Congress did not intend to limit the Secretary's authority to enforce the 133⅓% cap. DEFRA was, after all, primarily a deficit reduction measure. There is, therefore, no reason why Congress would have enacted, as

Respondents' remaining contentions are similarly flawed by their deliberate confusion of the "single standard" provision with the 133⅓% cap. For example, respondents point to language in the Conference Report concerning "adult couple MNILs" (Br. in Opp. 6). That report states that the moratorium was directed inter alia at the "position that the 'single standard' requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples." H.R. Conf. Rep. 98-861, *supra*, at 1367 (quoted in Br. in Opp. 7-8). This statement obviously refers only to the TEFRA "single standard" provision; it does not refer to the 133⅓% cap. As we have noted, an "adult couple MNIL" like California's may be objectionable on two distinct grounds: (1) in relative terms, because it treats some two-person families better than other two-person families for Medicaid purposes, in violation of the "single standard" rule; and (2) in absolute terms, because it sets Medicaid benefits for a two-person family at a level higher than 133⅓% of the maximum AFDC benefits for a two-person family, in violation of Section 1903(f). In addressing "adult couple MNILs" in the context of the DEFRA moratorium, Congress was referring only to the former ground of invalidity. This case concerns the latter.[19]

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part of budget-cutting legislation, a provision that would preclude the Secretary from enforcing the statutory cap on federal financial participation in Medicaid without at least explicitly stating its intent to do so.

[19] Even as to the effect of the DEFRA moratorium on the Secretary's powers under Section 1902(a)(10)(C)(i)(III), Judge Kozinski noted (Pet. App. 34a) that the moratorium "prohibits the Secretary from taking any regulatory action

In sum, there is no basis for assuming that Congress intended the DEFRA moratorium to apply to the situation involved here. Section 1903(f) is not within the scope of the moratorium's statutory language, is not mentioned in the Conference Report's description of the moratorium's purpose, and is a provision that the Conference Report expressly refused to amend only six pages earlier. Cf. *Gulf Oil Corp.* v. *Copp Paving Co.*, 419 U.S. 186, 200 (1974) (Conference Committee's deletion of phrase from bill "strongly militates against a judgment that Congress intended a result that it expressly declined to enact."). And once the clear statutory distinction between Section 1903(f) and Section 1902(a)(10)(C)(i)(III) is recognized, respondents' attempt to draw support from DEFRA's legislative history evaporates.

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against a 'State's [Medicaid] plan.'" Since California's "proposed amendment does not become part of its plan [until approved by the Secretary]," Judge Kozinski observed, the State "therefore cannot benefit from the moratorium" in this case. *Ibid.*

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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